Prior Authorization

Many drug products require prior authorization (PA) **before** the pharmacist provides them to the client. Requests are reviewed for medical necessity.

- To request prior authorization, providers must submit the information requested on the *Request for Drug Prior Authorization Form* to the Drug Prior Authorization Unit. This form is at the end of this document.
- The prescriber (physician, etc.) or pharmacy may submit requests by mail, telephone, or FAX to:

  Drug Prior Authorization Unit
  Mountain Pacific Quality Health Foundation
  3404 Cooney Drive
  Helena, MT 59602

  (406) 443-6002 or (800) 395-7961 (Phone)
  (406) 443-7014 or (800) 294-1350 (Fax)

- Requests are reviewed and decisions made immediately in most cases. Decisions on requests with special circumstances that require further peer review are made within 24 hours. Requests received after the PA Unit's regular working hours of 8 a.m. to 5 p.m. Monday through Friday, or on weekends or holidays are considered received at the start of the next working day.
- An emergency 72-hour supply may be dispensed for emergency after-hours/weekend/holiday requests. Payment will be authorized by using a "3" in the *days supply* field and a Medical Certification code of "8" in the *PA/MC code* field.

Prior Authorization for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, he or she should present the provider with an FA-455 (eligibility determination letter). Providers may choose whether or not to accept retroactive eligibility (see the *General Information For Providers* manual, *Client Eligibility* chapter). All prior authorization requirements must be met to receive Medicaid payment. When requesting PA, attach a copy of the FA-455 to the PA request. It is the client's responsibility to ensure his or her caseworker prepares an FA-455 for each provider who participates in the client's health care during this retroactive period. See the *Billing Procedures* chapter in the manual for retroactive eligibility billing requirements.

All prior authorization requirements must be met for retroactively eligible clients.

Medicaid PA Criteria

Drug	Criteria
Actiq Lozenges (fentanyl)	• No history of MAOI use within the last 30 days • Initial doses greater than 200mcg will not be approved. Initial therapy will be defined as patients not having Actiq therapy in the last 30 days • Non-cancer diagnoses will not be approved • Greater usage than 4 units of any strength per day • Authorization for existing usage in pain of non-cancer origin will be granted on an individual basis in consultation with the prescriber to prevent withdrawal syndromes.
Aggrenox (aspirin/dipyridamole)	For prevention of recurrent stroke in patients who have experienced a transient ischemic attack or previous ischemic stroke and who have had a recurrent stroke while on aspirin or have failed plavix.
Antiemetics Kytril Tablets and oral solution. PA required for quantities greater than 10 units in a 30-day period. Zofran Tablets and oral solution. PA required for quantities greater than 15 units in a 30-day period. Anzemet Tablets PA required for quantities greater than 5 units in a 30-day period.	For prescription exceeding monthly quantity limits for the prevention of nausea and vomiting associated with chemotherapy/radiation therapy, or for nausea and vomiting associated with pregnancy when traditional therapies have failed. Quantity limits for these and other indications will be considered on a case by case basis.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.
Avinza (Morphine sulfate extended-release capsules) PA required for quantities greater than once daily.	Requests exceeding these quantity limits will be considered on an individual basis.

Medicaid PA Criteria (continued)

Drug	Criteria
COX-2 Inhibitors Celebrex (celecoxib) Bextra (valdecoxib)	No history of aspirin sensitivity or allergy to aspirin or other NSAID, and/or aspirin triad, and at least one of the following: • History of previous GI bleeding within the last 5 years • Current or recurrent gastric ulceration • History of NSAID-induced gastropathy • Currently treated for GERD • For clients 65 years of age • Currently on anticoagulant therapy
Dipyridamole	As adjunct to warfarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacement.

Disease-Modifying Anti-Rheumatic Drugs (DMARD)
 	
Arava (leflunomide)
Enbrel (etanercept)
Humira (adalimumab)
Kineret (anakinra)
Remicade (infliximab)
	• Diagnosis of rheumatoid arthritis
	• Rheumatology consult with date and copy of consult included
	• Kineret may be used alone or in combination with DMARD's other than tumor necrosis factor (TNF) blocking agents (i.e. Enbrel)
	  • Enbrel whether alone or in combination with methotrexate.
	  • Enbrel or Remicade may be approved with Arava on an individual basis.
	  • Remicade when used in combination with methotrexate may be approved for first-line treatment in patients with moderately to severely active rheumatoid arthritis as evidenced by:
	  • > 10 swollen joints
	  • ≥ 12 tender joints
	  • Elevated serum rheumatoid factor levels or erosions on baseline x-rays
	  • Remicade therapy will only be approved following a negative
	  • TB test
	  • Enbrel also covered for psoriasis when accompanied by a prescription from a dermatologist.

Remicade (infliximab)	Also covered for the following diagnoses: • Moderately to severely active Crohn's disease for patients with an inadequate response to conventional therapy • Fistulizing Crohn's disease
Erectile Dysfunction Viagra (sildenafil) Cialis (tadalafil) Levitra (vardenafil) Quantity limited to one (1) tablet per month	• Diagnosis of erectile dysfunction. • Males only, 18 years of age or older. • No concomitant organic nitrate therapy.

Medicaid PA Criteria (continued)

Drug	Criteria
Gastro-intestinal drugs Includes H-2 antagonists, proton pump inhibitors, and Cytotec Prior authorization is required only for concomitant usage of an H2-antagonist and a proton pump inhibitor. This PA requirement is designed to avoid therapeutic duplications.	Diagnosis of: • Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas) • Symptomatic gastroesophageal reflux (not responding or failure of maintenance therapy) • Symptomatic relapses (duodenal or gastric ulcer) on maintenance therapy • Barretts esophagus • GERD Other conditions considered on an individual basis.
Growth hormones	Diagnosis of: • Growth hormone deficiency in children and adults • Growth retardation of chronic renal insufficiency • Turner's Syndrome • AIDS-related wasting Children and adolescents must meet the following criteria: • Standard deviation of 2.0 or more below mean height for chronological age • No expanding intracranial lesion or tumor diagnosed by MRI • Growth rate below five centimeters per year • Bone age 14-15 years or less in females and 15-16 years or less in males • Epiphyses open **Growth hormone deficiency in children:** Failure of any two stimuli tests to raise the serum growth hormone level above 10 nanograms/ milliliter. **Growth retardation of chronic renal insufficiency:** Irreversible renal insufficiency with a creatinine clearance <75 ml/min per 1.73m^2 but pre-renal transplant. Turner's Syndrome: Chromosomal abnormality showing Turner's syndrome. Growth hormone deficiency in adults: • **Adult Onset:** Patients have somatotropin deficiency syndrome (SDS) either alone or with multiple hormone deficiencies, (hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma. • **Childhood Onset:** Patients who had growth hormone deficient during childhood and now have somatotropin deficiency syndrome (SDS).

Medicaid PA Criteria (continued)

Drug	Criteria
Thalomid (thalomide)	Treatment of the cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL). Considered for other diagnoses on individual basis.
Toradol (ketorolac) For quantity greater than a 5-day supply within a month	Indicated for the short-term treatment of acute pain. Authorization considered on an individual basis.
Tretinoin PA required for patients 26 years and older.	Diagnose of: • Skin cancer • Lamellar ichthyosis • Darier-White disease • Psoriasis • Severe recalcitrant (nodulocystic) acne
Xanax XR (alprazolam extended-release tables)	• Xanax XR tables may be covered for patients who have not responded to adequate trials of at least two generic long-acting benzodiazepines, one of which is generic alprazolam. • Coverage of Xanax XR will be allowed for once daily dosing only.
Zoloft 25 mg & 50 mg (sertraline)	Authorized for patients requiring dosages where tab splitting would be inappropriate (i.e., 75 mg, 125 mg).
Zyvox (linezolid)	Adult patients with vancomycin-resistant enterococcus.

MHSP Prior Authorization Criteria

Drug	Criteria
buspirone (Buspar)	• Augumentation of depression and/or obsessive compulsive disorder (OCD). • Generalized anxiety disorder.
zaleplon (Sonata) zolpidem (Ambien)	Trial and failure with at least **two** multi-source prescription sleep-inducing drugs.
amotrigine (Lamictal)	• Diagnosis of bi-polar disorder.
guanfacine (Tenex) isradipine (DynaCirc) levothyroxine sodium (Synthroid) liothyronine sodium (Cytomel) pindolol (Visken) propranolol HCl (Inderal) verapamil, verapamil HCl (Calan)	Use as augmentation strategy specifically related to mental health treatment.
maprotiline HCl (Ludiomil)	Considered on an individual basis.
sertraline (Zoloft 25 mg & 50 mg)	Authorized for patients requiring dosages where tablet splitting would be inappropriate (i.e., 75 mg, 125 mg).
gabapentin (Neurontin)	Must specify if anxiety (generalized anxiety, panic disorder, post traumatic stress disorder) and/or compelling reason with bipolar disorder.
topiramate (Topamax)	Diagnosis of bipolar disorder, obesity, intolerance, time effective of Lithium, Depakote, Trileptal/Tegretol.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) and bill Medicaid for the service(s). For more information on retroactive eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Clients are responsible for cost sharing for Medicaid-covered prescriptions to a maximum of $25 per month.

For the prescription drug program, cost sharing is as follows:

- 5% of the Medicaid allowed amount with a minimum of $1.00 and a maximum of $5.00 per prescription.

The following drugs are exempt from cost sharing:

- Clozaril, all strengths
- Family planning prescriptions
- Compounded prescriptions for infusion therapy

The following are exempt from cost sharing:

- Clients under 21 years of age
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Nursing facility residents
- Clients with third party liability (TPL) when Medicaid is the secondary payer.

To exempt cost sharing on POS, enter a "4" in the *PA/MC code & Number* field. On a paper claim enter a "4" in *Drug Name* field. See Chapter 8 *POS* and Chapter 9 *Completing a Paper Claim*.

For clients with Mental Health Services Plan (MHSP) coverage, there is a $425 pharmacy cap. The MHSP program pays for the first $425 in prescriptions for the client each month, and the client must pay privately for any amounts over that cap.

Providers may choose to collect client cost sharing at the time of service or bill the client later. According to federal regulation, a provider cannot deny services to a Medicaid client due to the client's inability to pay cost sharing at the time services are rendered. However, the client's inability to pay cost sharing at the time services are rendered does not lessen the client's obligation to pay cost sharing.

National Drug Codes (NDC)

All outpatient prescription drugs are billed using the drug's NDC, the 11-digit code assigned to all prescription drug products by the labeler or distributor of the product under FDA regulations.

The Department accepts only the 5-4-2 NDC format. All 11 digits, including zeros, must be entered. The three segments of the NDC are:

The provider must always use the complete 11-digit NDC from the dispensing container.

SAMPLE NDC: 12345-6789-10
12345 = labeler code
6789 = product code
10 = package size

Claims must accurately report the NDC dispensed, the number of units dispensed, days supply, and the date of dispensing. Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause the Department to report false data to drug manufacturers billed for drug rebates.

The Department will recover payments made on erroneous claims discovered during dispute resolution with drug manufacturers. Pharmacies are required to document purchase for quantities of brands of drugs reimbursed by the Department if disputes occur.

Dispense As Written (DAW)

Prescribers and pharmacies must prescribe and dispense the generic form of a drug whenever possible. Except for those drugs listed below, prior authorization is required when a brand name drug is prescribed instead of a generic equivalent. Please use the following DAW codes for these situations:

- DAW 1 may only be used only if authorized by the Drug Prior Authorization Unit.
- DAW 5 may be used in instances where the drug dispensed is generic but is listed as a brand (Branded Generics).
- DAW 7 may be used for the following drugs without prior authorization:

  - Lanoxin/Lanoxicaps
  - Coumadin
  - Ritalin
  - Anti-hemophiliac factors
  - Thyroid medications
  - Tegretol
  - Cyclosporine products (i.e. Neoral, Sandimmune)
  - Clozaril
  - Dexedrine products
  - Cylert
  - Imuran
  - Adderal
  - Dilantin
  - Depakote